



Southwestern Forensic  
Associates, Inc.

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 11/21/09

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar myelogram

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine problems

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. forms
2. TDI referral forms
3. fax cover sheet
4. Denial letters 09/30/09 and 11/03/09
5. Fax cover sheet
6. Medical conference note, 11/03/09
7. Clinical records, 10/21/09, 09/30/09, 09/23/09
8. MRI scan of lumbar spines, 11/19/08
9. \_\_\_ lumbar spines x-rays, 08/11/09
10. Epidural steroid reports, 06/08/09, 06/24/09
11. Preauthorization request form, lumbar myelogram

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient is a male who suffers both cervical and low back pain. His date of injury is xx/xx/xx. The specific mechanism of injury is not documented. He has undergone at least three cervical surgeries including ACDF procedures in 2002, 2006, and a left C7 posterior cervical laminectomy in 2007. He complains of extensive low back pain without specific leg pain other than he does state that periodically he has right leg pain to his calf. His physical findings include no reflex abnormalities, no motor weakness, straight leg raising tests are negative, and his imaging studies reveal only mild disc bulging with degenerative disc disease at L4/L5. He has lumbar facet hypertrophy. He has undergone epidural steroid injections without significant benefit. He uses a transcutaneous electrical nerve stimulator on a periodic basis. A request for the performance of lumbar myelogram has been submitted and denied, reconsidered and denied.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

As an integral part of the establishment of medical necessity for a lumbar myelogram, the presence of radiculopathy suggestive of compressive neurologic disease should be established. In the absence of specific nerve root radiculopathy, lumbar myelogram cannot be justified. Furthermore, lumbar myelogram is no longer recommended under circumstances where MRI scans are available. The prior denials appear to have been appropriate and should be upheld. The medical necessity for the performance of lumbar myelogram has not been established as no radiculopathy has been documented.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

*(Check any of the following that were used in the course of your review.)*

- \_\_\_\_\_ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- \_\_\_\_\_AHCPR-Agency for Healthcare Research & Quality Guidelines.
- \_\_\_\_\_DWC-Division of Workers' Compensation Policies or Guidelines.
- \_\_\_\_\_European Guidelines for Management of Chronic Low Back Pain.
- \_\_\_\_\_Interqual Criteria.
- X  \_\_\_\_\_Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
- \_\_\_\_\_Mercy Center Consensus Conference Guidelines.
- \_\_\_\_\_Milliman Care Guidelines.
- X  \_\_\_\_\_ODG-Official Disability Guidelines & Treatment Guidelines, 2008, Cervical Spine Chapter, Discography passage.
- \_\_\_\_\_Pressley Reed, The Medical Disability Advisor.
- \_\_\_\_\_Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- \_\_\_\_\_Texas TACADA Guidelines.
- \_\_\_\_\_TMF Screening Criteria Manual.
- \_\_\_\_\_Peer reviewed national accepted medical literature (provide a description).
- \_\_\_\_\_Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)